

## Forgotten children?

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**Forgotten children? An update on young children in institutions across Europe**

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## **Abstract**

The worst of institutional care was brought to public attention in Romania during the 1990s when pictures of severely deprived and malnourished children were shown around the world. However, many European countries have high rates of young children in institutions, where the physical care of the child predominates, with social/emotional needs a secondary concern. Yet institutional care is a very poor substitute for positive family care, increasing the risk of development delay, attachment difficulties, neural growth dysfunction and mental health disorders. This article provides an update on a series of projects that have highlighted this issue in Europe, arguing that babies and small children aged less than 3 years old, with or without disability, should not be placed in residential care without a parent or primary caregiver. This principle has been discussed by the UN General Assembly (2009) and specific guidelines have been produced for all 193 member states.

Keywords: institutional care; young children;

## **Forgotten children? An update on young children in institutions across Europe**

Six years ago in the *British Medical Journal*, cause for concern was expressed by the authors<sup>1</sup> on the 'Overuse of institutional care for children in Europe'. An estimated 43,842 (14.4 per 10,000) children less than 3 years resided in institutional care within 46 countries of the WHO European and Central Asian region. Within Europe, it was found that institutional care of young children was not restricted to countries in transition but was common throughout the entire region, with less than 4% registered as biological orphans<sup>2,3</sup>. The majority were placed there due to child maltreatment, parent 'abandonment' or because of a disability, despite the knowledge that institutional care is a very poor substitute for positive family care, increasing the risk of development delay, attachment difficulties, neural growth dysfunction and mental health disorders.

Six years on, the United Nations General Assembly Report of the Human Rights Council in its 11<sup>th</sup> Session produced 'Guidelines for the Alternative Care of Children' for 192 Member States. Paragraphs 21 and 22 highlighted the need for member states to adopt a "deinstitutionalization objective and strategy" particularly for children under the age of three years<sup>4</sup> (see Table 1). In a similar vein, one of UNICEF's top priorities is to ensure that babies are not cared for in institutional settings. Alongside international work done by UNICEF<sup>5</sup> and non-governmental organisations (e.g., Every Child, Save the Children), the Brazilian government and the CRC committee, a series of projects devised by the authors and funded by the European Union Daphne programme and the World Health Organisation Regional Office for Europe have highlighted this issue in Europe and helped to raise the profile of these forgotten children.

(Table 1 here)

### **The projects**

The worst of institutional care was brought to public attention in Romania during the 1990s after the fall of Ceaușescu in 1989, when pictures of severely deprived, malnourished and poorly cared for children were shown around the world. However, as outlined in the original article, in 2003 the first of the three projects led by the two authors (with a large team of

partners across Europe<sup>a</sup>) showed this problem to exist in most of the 33 European countries surveyed<sup>2</sup>. To summarise, official government data showed that 23,099 young children less than 3 years old (approximately 11 per 10,000 children) were in institutional care<sup>b</sup> for more than three months without a parent in 31 countries in European Union, Economic Community and accession countries. Rates ranged from less than one per 10,000 young children (e.g., UK, Iceland, Slovenia), to eight countries with 31 to 60 per 10,000 babies and small children in institutions (Czech Republic, Belgium, Bulgaria, Latvia, Lithuania, Romania, Slovak Republic and Hungary). There were a significantly higher proportion of boys, although whether this is because they are more likely to be placed there or less likely to be quickly moved on to alternative family based care is unclear.

One of the most interesting findings was that many 'western' European countries (e.g., Belgium, Finland, Spain, the Netherlands, Portugal and France) also had high rates of very young children in institutional care, challenging the preconception that this was an issue only for the 2003 EU accession countries (later to join the EU in 2004 and 2007). Hence, it is an issue which every country in Europe needs to consider, not least in terms of why babies and toddlers are being placed away from their parent(s) in the first place.

### **Why are children in institutions?**

For EU countries, for more than two-thirds this reflected issues of child maltreatment, whereas child abandonment (approximately one-third) and disability (approximately one-quarter) were more common in the other countries which also had lower GDP, lower health expenditure, younger mothers and a higher rate of termination of pregnancies. Thus, we must be very cautious about our interpretation of why some parents feel unable to maintain care of their own children and take the undoubtedly difficult decision to leave a child in residential care. Similarly, if children are to be removed from parental care due to suspected

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<sup>b</sup> Defined as 11 or more children

or proven maltreatment, then surely we have a duty of care to ensure that the substitute care they are provided is less (not more) damaging?

Wider issues related to provision of social care and health are also important. For example, one major difficulty is that many countries (e.g., Portugal, Hungary) did not have or were still developing alternative care systems, such as foster placements. Of the few 33 European countries assessed in 2003, only Norway, Iceland, Slovenia and the UK had a successful policy to provide foster homes for all young children rather than use institutions<sup>1</sup>. Ideally this would apply also to older children but is not always possible given the shortage of foster placements and adoptive placements. Thus, despite the fact that the study also showed that institutional care is more expensive for children both with and without disabilities, one third of countries in Europe placed more babies and young children in institutions than in foster or kinship care<sup>2</sup>.

Some countries argue that their institutions are better quality and provide good substitute care. Certainly, there was evidence of differences but, nevertheless, in all institutions across Europe, the physical care of the child predominated, with social and emotional needs a secondary concern and little opportunity for regular one-to-one caregiving.

### **The dangers of institutional care**

Why is this so concerning? In summary, the role of families and early relationships in the positive development of children is widely recognised, leading to a reduction in risk of anti-social behaviour and violence to others, both in and outside of the home. Optimal child development requires the opportunity for frequent one-to-one interactions with a consistent caregiver. In contrast, it is known that extreme early deprivation of sensitive and consistent parenting leads to attachment disorder<sup>6,7</sup>, but also to neural atrophy, cognitive and personality difficulties<sup>8,9,10,11</sup>. Children placed in a caring family environment by the age of 6 months can recover and many can achieve physical and cognitive development in the 'normal range' by 16 years, although are likely to continue to show difficulties in areas such as peer relationships, social behaviour and attachments<sup>12</sup>, leading to a greater chance of antisocial behaviour and mental health problems<sup>13</sup>.

Thus, any time spent in institutional care is particularly crucial for babies and small children for whom likely prognosis deteriorates as the length of time spent in that environment increases<sup>14,15,16</sup>. It is certainly an environment where even the most resilient of children would struggle to develop appropriate social and emotional relationships. Finding the best ways to prevent children entering institutions and/or moving them on from institutions to appropriate family based care as soon as possible is therefore key.

### **Good practice in deinstitutionalising children**

Thus, having established the rate of babies and small children in institutions, the two subsequent projects identified ways in which young children were being moved out of institutions and returned to family-based care in seven European countries<sup>c</sup> and established a model of good practice which was initially offered to the eight European countries<sup>d</sup> with the highest rates of institutionalisation.

In terms of de-institutionalising and transforming children's services across the seven countries surveyed, it was identified that 19% of children being moved were returned to their parents or relatives, 63% entered a new family via foster care or adoption but 11% were moved to another institution with 11 or more children and 7% were placed in another non-family setting, such as a specialist home for children with disabilities<sup>17</sup>. Thus, overall, nearly one in five of those supposedly de-institutionalised remained in an institutional environment. The average amount of time that a child from the sample had spent in institutional care was 15 months (range 10-20 months<sup>17</sup>). In countries with better community support services, the child's needs were considered in decisions about placement, but disability and sibling placements were often not considered. The findings overall demonstrated that the practice of moving children from residential to family-based care needs further improvement. This needs to take account of the fact that sudden relocation to unfamiliar carers without appropriate support in place (e.g., from community health and social services) could result in placement breakdown and further damage to the child.

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<sup>c</sup> Denmark, France, Greece, Hungary, Poland, Romania and Slovak Republic

<sup>d</sup> Czech Republic, Belgium, Latvia, Buglaria, Lithuania, Hungary, Romania and Slovak Republic

A model of good practice was developed by Mulheir, Browne and Associates<sup>e</sup> in 2007 (<sup>18</sup>;Table 2) and offered as a free two-day training course for policy makers and practitioners. Most of the countries offered the training were very pleased to accept. Two exceptions were the Czech Republic and Bulgaria who refused the offer, although it should be acknowledged that at the time they had been receiving very negative press in the UK with the images of ‘caged children’ and poor living conditions (respectively). Furthermore, it is notable that the Czech Republic, Bulgaria and other new EU member states are now making legislative changes to ensure that no child under the age of three years should be placed in institutional care following specific UN Guidelines.

(Table 2 here)

Despite these two initial refusals, within one year the principle of deinstitutionalising young children into family based care to reduce harm was disseminated in sixteen 2003 EU member/EU accession countries and four other countries in the region. One key element of this has been to argue that babies and small children aged less than 3 years old, with or without disability, should not be placed in residential care without a parent or primary caregiver. As highlighted above, this principle has now been discussed by the UN General Assembly (2009) in relation to human rights and specific guidelines have been produced for all 193 member states. This has led to a worldwide campaign by UNICEF and non-governmental organisations (e.g., Save the Children, Everychild) to end the institutional care of children less than 3 years, consistent with the authors recommendation in the 2006 BMJ article<sup>1</sup> *‘that no child less than 3 years should be placed in residential care without a parent’* (page 7).

Following our training and good practice manual<sup>18</sup>, there are examples of European residential care institutions (both large and small) being transformed into polyclinics for children’s services (see Table 3). These include day care for children with and without disabilities (who then return home to their parents, kinship or foster carers in the evening and at weekends), mother and baby units (shelters) for mothers at risk of violence or

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<sup>e</sup> Hamilton-Giachritsis plus partners listed in footnote 2



abandoning their child, and new family-like apartments for emergency care provision of street children, refugees and children in adversity. These two to three bedroom apartments (with a lounge and kitchen) have no more than five or six children of different ages and abilities living there. They have their own space and belongings and, where possible, siblings share the same bedroom. The children are cared for by two or more surrogate carers at all times. The carers are the same each day and the aim is to relocate the children into their own kinship/foster families within 6 months.

(Table 3 here)

### **The way forward**

At a societal level, the subject of child protection is one of the priorities of the European Community. Member states are increasingly committed to implementing both preventative measures and protective services for abused and neglected children, with reference to the Convention of the Rights of the Child (i.e., what is in the best interests of the child).

Therefore, the general public, media, policy makers, health and social workers in all European countries should be interested in the eradication of early privation and the use of institutions for the care of young children in adversity. Having had this significant problem identified by a number of sources, it is heartening to see that many countries, both in Europe and beyond, have recognised the damage done to small children 'cared for' in institutions and have been making steps to move forward.

However, the position is not all positive. The progress made to date is in danger of being undermined by the current financial climate and the difficulties (particularly for some European countries) that is leading to a worrying rise in the rate of infant abandonment and, in some cases, prompting a return to the practice of leaving small babies together for hours in cots. As professionals working in this field, we must do all we can to continue to highlight the worrying consequences of such care and promote alternative care arrangements.

**Role of the funding source**

The three projects were funded 80% by the European Union Daphne programme and 20% by the World Health Organization Regional Office for Europe. The EU role was funding and review of the project only; they encourage publication of the material in peer-review journals. The World Health Organisation Regional Office for Europe was involved in the planning and ethical review of all three projects reported in this update review, as well as involvement in data collection (lead: Dr Mikael Ostergren).

**Disclosure statement / conflict of interest**

No authors have any financial relationships with any organisations that might have an interest in the submitted work in the previous 3 years; no other relationships or activities that could appear to have influenced the submitted work.

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Table 1.

*‘Guidelines for the Alternative Care of Children’ for 192 Member States, from United Nations General Assembly (2009) Report of the Human Rights Council in its 11<sup>th</sup> Session (A/HRC/11/37, Section 11/7, p.23).*

Paragraph 21	In accordance with the predominant opinion of experts, alternative care for young children, especially those under the age of 3 years, should be provided in family-based settings. Exceptions to this principle may be warranted in order to prevent the separation of siblings and in cases where the placement is of an emergency nature or is for a predetermined and very limited duration, with planned family reintegration or other appropriate long-term care solution as its outcome.
Paragraph 22	While recognizing that residential care facilities and family-based care complement each other in meeting the needs of children, where large residential care facilities (institutions) remain, alternatives should be developed in the context of an overall deinstitutionalization strategy, with precise goals and objectives, which will allow for their progressive elimination. To this end, States should establish care standards to ensure the quality and conditions that are conducive to the child’s development, such as individualized and small-group care, and should evaluate existing facilities against these standards.
	Decisions regarding the establishment of, or permission to establish, new residential care facilities, whether public or private, should take full account of this deinstitutionalization objective and strategy.

Table 2:

*The Ten Step Model (taken from Mulheir, Browne & Associates, 2007, with permission)*

<b>STEP 1</b>  <i>Raising awareness</i>	Raising awareness of the harmful effects of institutional care on young children and their development.
<b>STEP 2</b>  <i>Managing the process</i>	The establishment of an effective multi-sector project management team (at national and regional levels) to pilot projects in one or more areas or institutions.
<b>STEP 3</b>  <i>Country level Audit</i>	To audit the nature and extent of institutions for residential care of children nationally and to measure the number and characteristics of children who live in them.
<b>STEP 4</b>  <i>Analysis at institution level</i>	Data collection and analysis within an institution of admissions, discharges and length of stay of children and an assessment of individual needs of the children in residence.
<b>STEP 5</b>  <i>Design of alternative services</i>	Design of alternative services based on individual needs of children and an assessment of family based services currently available (e.g. mother baby unit for parents at risk of abandonment) and those new services that need to be developed (e.g. day care and foster care services for children with disabilities).
<b>STEP 6</b>  <i>Plan transfer of resources</i>	Management plan and practical mechanism for the transfer of resources - financial, human, and capital. Finances should always follow the child.

<b>STEP 7</b>  <b><i>Preparing and moving children</i></b>	<p>Preparing and moving children and their possessions on the basis of their individual needs and treatment plans. Matching these needs and plans to the new placement and the capacity of the new carers. Transfer procedures need to respect the rights of the child and always be in their best interest.</p>
<b>STEP 8</b>  <b><i>Preparing and moving staff</i></b>	<p>Preparing and moving staff by assessing staff skills, staff training needs and staff expectations in relation to the new demands of transformed services for children.</p>
<b>STEP 9</b>  <b><i>Logistics</i></b>	<p>Carefully considering logistics to scale up a successful pilot project involving one institution or one region, to a national strategic plan.</p>
<b>STEP10</b>  <b><i>Monitoring and evaluation</i></b>	<p>Setting up a national database of children in public care to monitor and support the transfer of children from institutional care to family based care. This involves health and social service staff making home visits to families with deinstitutionalised or newly placed children to assess, monitor and evaluate the treatment plans and optimal development of the children.</p>

Table 3.

*The way forward – moves to change institutions into alternative community services*

Provision	Purpose
Day care for children with and without disabilities	Maintained at home with parents, kinship or foster carers in the evening and at weekends
Mother and baby units (shelters)	For mothers at risk of violence, substance abuse or abandoning their child – works to maintain mother-child relationship
Family-like apartments for emergency care provision of street children, refuges and children in adversity (5-6 children at a time)	Provide children with their own space and belongings shared with a sibling, where possible. The children are cared for by the same two or more surrogate carers at all times and the aim is to relocate the children into their own kinship/foster families within 6 months